HIT Policy Committee
Transcript
May 30, 2012

Roll Call

Operator

All lines are now bridged.

Mary Jo Deering – Office of the National Coordinator – Senior Policy Advisor

Thank you, operator. Good afternoon, this is Mary Jo Deering in the Office of the National Coordinator and this is the meeting of the HIT Policy committee. It is a public call and there will be an opportunity for public comments at the end.

I'll begin by the taking the roll. Farzad Mostashari.

Farzad Mostashari – Office of the National Coordinator – National Coordinator for Health Information Technology

Here.

Mary Jo Deering – Office of the National Coordinator – Senior Policy Advisor

Okay, Madhu Agarwal. David Bates.

David Bates – Brigham and Women's Hospital – Senior Vice President for Quality and Safety

Here.

Mary Jo Deering – Office of the National Coordinator – Senior Policy Advisor

Christine Bechtel.

Christine Bechtel – National Partnership for Women & Families

Here.

Mary Jo Deering – Office of the National Coordinator – Senior Policy Advisor

Neil Calman.

Neil Calman – Institute for Family Health – President & Cofounder

Here.

Mary Jo Deering – Office of the National Coordinator – Senior Policy Advisor

Richard Chapman.

Larry Wolf - Kindred Healthcare - Health IT Strategist

Larry Wolf for Rick Chapman.

Mary Jo Deering – Office of the National Coordinator – Senior Policy Advisor

Patrick Conway. Art Davidson.

Art Davidson – Public Health Informatics at Denver Public Health – Director

Here.

Mary Jo Deering – Office of the National Coordinator – Senior Policy Advisor

Connie Delaney. Paul Egerman. Judy Faulkner. Mark Frisse.

Mark Frisse – Vanderbilt University – Accenture Professor of Biomedical Informatics

Here.

Mary Jo Deering – Office of the National Coordinator – Senior Policy Advisor

Gayle Harrell. Gayle, I thought I heard you on. Are you on mute? I thought I heard Gayle on. Charles Kennedy. David Lansky.

David Lansky – Pacific Business Group on Health – President & CEO

Here.

Mary Jo Deering – Office of the National Coordinator – Senior Policy Advisor

Deven McGraw.

Deven McGraw – Center for Democracy & Technology – Director

Here.

Mary Jo Deering – Office of the National Coordinator – Senior Policy Advisor

Frank Nemec. Marc Probst. Josh Sharfstein.

David Sharp – Maryland Health Care Commission

David Sharp for Dr. Sharfstein.

Mary Jo Deering – Office of the National Coordinator – Senior Policy Advisor

Latanya Sweeney. Rob Tagalicod. Scott White. Okay. I'll turn it over to you, Paul, thank you very much.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, and I think, Farzad, did you want to make any opening comments?

Farzad Mostashari – Office of the National Coordinator – National Coordinator for Health Information Technology

Sure, I just wanted to remark on this group that just does not lay down work until it is done, even if the … is officially over, and I'm very grateful to you for considering these issues and making sure that at the least the record reflects the full deliberations across the committee on the final very important issue.

I also want to mention that some of the members of … terms are going to be expiring on this regular schedule and as that we've initiated the membership funding process for those members with expired terms, there's going to be a Federal Registry notice that's going to be published hopefully by the end of this week that's going to explain the details of that process; and we're going to be requesting nominations to be submitted by Monday, June 11th and it is open to those with expired terms, are eligible to be nominated for a second term. We're going to notify people on when the Federal Registry notice has been posted and we encourage you all to spread the word.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Great, thank you, Farzad. As he mentioned this is a continuation of our earlier May meeting when we didn't have enough time to complete the comments and feedback or comments back to ONC on the standards and certification NPRM, so they were gracious in letting us provide some additional feedback even though the official expiration date has passed.

So we're covering a couple things, things related to the NPRM from the information exchange workgroup and from the certification adoption work group. We will have a little presentation by each group who will be walking through the comments as we did in the face to face meeting from the IE workgroup. Micky Tripathi is going to lead us through that, I believe. Then Larry is going to lead us through the certification adoption workgroup's comments on the NPRM following that.

Remember that we do have to finish. We don't get any additional time after today's call, so let's be respectful of the time and make sure we can get through all the material in the allotted time.

So is Micky going to be walking us through the first set?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Yes, I'm here, Paul.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Great, thank you, Micky.

Scott White – 1199 SEIU – Assistant Director & Technology Project Director

Paul, just before you go, it's Scott. I'm back on the line, sorry to interrupt.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Thank you.

Carl Dvorak – Epic Systems – EVP

Paul, this is Carl. I joined on behalf on Judy today who is on vacation.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay. Thank you. All right, Micky, why don't you go ahead?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Okay, great. This is Micky Tripathi, Chair of the IE workgroup and thanks for the opportunity to follow-up from the last meeting and finish the description of our comments and recommendations and suggestions from focusing in particular on public health.

What I'm going to do—I apologize, I'm in the car, so I'm not going to be able to follow exactly with what you have in front of you. But what I thought might make sense in the interest of time, and I know certifications options workgroup has a bunch of stuff to go through as well, is do it in priority order in terms of where I think the workgroup had sort of the strongest and the sharpest recommendations and then work our way backward.

Really the one that I would like to introduce first is the, I think it's bullet number two that you have there, which relates to the policy on the application of the standards for public health transmissions. You may recall that the NPRM recommends the unification where we're driving a single standard for public health transactions. We're in stage one. The previous edition, it was 2.3.1 or 2.5.1. Now the recommendation is to require 2.5.1.

The workgroup strongly endorses that from a technology and from a standards perspective. However from an economics and a policy perspective, we had one concern and wanted to make a recommendation that there be grandfathering of the 2.3.1 standard for a very particular group or cohort, and those would be the group of providers who attested to the public health objective in stage one. They did it with 2.3.1, and they continued to submit public health transactions according to that standard, so they went beyond the one test and they're still on their same EHR and the public health department in question, wherever that is, continues to accommodate 2.3.1 transactions.

The recommendation of the workgroup is that providers who fall into that category with a narrow set of four conditions be allowed to be grandfathered in to continue with the 2.3.1 standard until such time as any change happens, or they hit the next … threshold. From that recommendation is that there's a concern that vendors will charge those providers to switch from 2.3.1 to 2.5.1, which in some sense feels like it's not particularly fair to that group of providers who are actually doing the right thing and continue to do the right thing according to the guidance that was given to that stage one. So that's why the workgroup felt that this—though it could be a fairly small set of providers in the scheme of things, … not be penalized for doing that; for continuing to do that.

Let me pause here. Paul, did you want to discuss each of these in turn?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes, why don't we go ahead and do that, any comments from that recommendation? Okay, so let's see. Could I get a, without the body language it's hard to read. I'm going to take this, so please speak up if there are objections to this. May I take a lack of any comment to saying this is a consensus … recommendations?

Deven McGraw – Center for Democracy & Technology – Director

I think you can, Paul. This is Deven, and I confess that I don't know a whole lot about this issue, but the information exchange workgroup is really stacked with a lot of experts in this field; and so even though I don't know very much about it, I'm certainly comfortable with the recommendation and believe it's well informed.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

One of the things is really optionality sometimes really gets in the way, and we're recommending to reduce that with the exception of a grandfather where people who have already done things already felt responding would a shame to penalize them as we have one of those principles ….

Okay, go ahead, Micky.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Okay, great. The second one is a little bit softer, so it may be that the policy committee may or may not want to pick a specific sort of vote on this one, but it's related in general to the concern of the workgroup that the definition of a successful ongoing submission be more concrete than it is in the NPRM. So you may recall that from stage one, there was a single test and now we want to move people to ongoing submission, and in other categories, we give specific percents; whether it's eprescribing, …, whatever it is, but for public health, the only requirement was that it be successful ongoing submissions. It seems that there was a need for greater specificity among what that ought to mean. There are a variety of ways of approaching that. We stick with a specific recommendation that I think was more in the favor of feeling like we're going through a stage that we should be forced, that we should at least give the policy committee something to chew on. I think that there was probably a number of different ways that one could approach this one, but the recommendation that we came up with was something on the order of saying that 10% of the public health transactions ought to be submitted electronically going up ten percentage points a year up to a maximum of 50%.

The reason was on the one hand, we're moving from just a test to ongoing submissions. So we wanted to on the one hand, these are required by law or certainly with the layer that we now have of except where prohibited by law, there is a sense that this ought to be all or none. On the other hand, with almost all of the requirements and objectives we've been going through, we try to provide some kind of ramp or glide path, and in this case, trying to compromise between the two, we wanted to provide some kind of ramp, but make it a steep one, which is how we came up with the idea of starting at 10%, but moving relatively quickly to 50%.

Now as I said, I think that there probably wasn't really full discussion at the workgroup about this particular objective in terms of the numerical requirement, but we did feel that we were obliged to provide something to further the discussion on the point. The general point was more related to there not being a definition of successful ongoing submission and the need for having one if we're going to make this an objective.

Gayle Harrell – Florida – House of Representatives

This is Gayle. I have one question if I may.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes, go ahead, Gayle.

Gayle Harrell – Florida – House of Representatives

Do we have any idea how many public health entities are capable of taking the submissions? I mean, is this going to become a problem in areas presumably if they don't have the capability, if the public health entities do not have the—whether it's the departments of health or agencies throughout their administration, whoever is in charge in whatever state, if they don't have the capabilities, then of course, it should not be a requirement.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Right, they get exclusions.

M

...

Gayle Harrell – Florida – House of Representatives

Yes, but just in general, do we have any idea how many states are capable of doing this?

Art Davidson – Public Health Informatics at Denver Public Health – Director

This is Art and I think ASCO has done some surveying. I don't know if Jim Daniels is on the phone for ONC, but it's been an increasing number; and I think it's extended up to well over half the states are now capable of receiving some of the types of data, like immunization. So it's increasing, but it's not complete. There will be exceptions, yes.

Gayle Harrell – Florida – House of Representatives

Okay, thank you.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I have a comment on the escalating percent. We have this parsimony rule about the number of requirements, but I think parsimony would apply here in terms of the complexity to administer this program, so I wonder if you could accept a single number and just carry to the entire stage and maybe into single numbers. Once you start this thing going, I don't know if anybody would withhold any, but as long as—

Art Davidson – Public Health Informatics at Denver Public Health – Director

This is Art. Before we spend too much time on this, in order for us to be able to—my understanding just for the committee to consider in general, is if there are concrete proposals in the NPRM, then people have an opportunity to respond and comment, which we can then finalize rules based on those comments.

I think for the purposes of maybe future rulemaking, it's helpful to provide these kinds of new approaches, but I think we have to recognize that the community probably deserves an opportunity to comment on any specific proposal like this as part of rulemaking for …. I don't if this is something that relates … that. I don't know … want to comment more. But my concern is just not to spend too much time on very specific proposals that were not in the NPRM if the … would be there for including getting the final rules.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay.

Larry Wolf - Kindred Healthcare - Health IT Strategist

This is Larry Wolf, just a quick thought about this. Since we seem to be on about a two year interval between stages of meaningful use, even if we didn't do this sort of automatic ramp-up that's being discussed here, there is no reason to not expect that there wouldn't be a higher level of submissions in stage three. As far as Art was saying, if we were looking to ramp it up to go faster, that might be an appropriate time to raise that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, so I think it was … that was saying we can't go beyond what would be more stringent or rigorous than what was proposed. Is it acceptable to put out a number, Farzad?

Farzad Mostashari – Office of the National Coordinator – National Coordinator for Health Information Technology

I think, look, this is sense of the policy committee that's going to go into the official record, you're welcome to offer us a thought about what it should be. I just want to caution us to be aware of what is feasible and is not feasible within the constraints of the ….

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes, okay, I think that means just coming with this new algorithm might be a bit of a stretch. So I think your main message is that we would define it, you're giving some quantitative number to making sure people would understand what it takes to qualify and maybe that's really what needs to be communicated.

M

Yes, I think that was the main point.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Are people okay with that?

W

Yes.

W

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So now we're now going to have to worry about timing. We've got to get through—we probably have about 15, 20 more minutes, so let's try to pace ourselves and we'll try to get as much consensus as we can. Go ahead, Micky.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

No, I think that's it, Paul. The only other one was really just a general statement about concern about the NPRM allowing too much flexibility for local public health departments. I think that was just a general comment that's pretty explanatory and that can be communicated in the written letters that we have. So I give back my time to you and to the policy committee.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

What about these others, the other two pages?

M

The other two pages are the bullet items from the verification adoption work.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Sorry, okay, so if there's any other either discussion or is there something you want to add, Micky?

I got confused and thought ….

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

No, I don't think so. I appreciate the time.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay. Any other comments by the committee? Okay, let's move on to certification adoption then.

Larry Wolf - Kindred Healthcare - Health IT Strategist

So let me begin by thanking everybody for making this time today. We certainly did get in a time crunch and the workgroup really appreciates having a chance to bring this to the policy committee for discussion. In this sort of a time crunch that happened, there never was a time to present for deliberation by the policy committee prior to the final meeting back in May, so it's good to have a chance to recover from that planning problem.

So we're going to be walking through the slides. I apologize, I'm not on the web, so I can't navigate what you're seeing, so I'll try and talk through where we ought to be.

So looking at the slides, the work group members on slide one had several calls and many of the members came forward to take a lead on each of the specific topic areas we're going to cover, so it's really a great collaborative effort that got us these recommendations.

So moving on to slide two, the intention here is really focused on policy issues. We found that we found the standard side of NPRM and the questions being asked very productive, but we really to tried to back off and talk more about more policy related issues than details of any particular standard or standard implications in the NPRM. So we'll be covering these eight topics, which sort of gives us a little bit less then ten minutes each to present them and talk about them and come to a conclusion, so let's see if we can stay on track with that.

So moving on to the next slide, so the way we started to organize is one of the eight topics for discussion that was in the request for comment section of the NPRM is highlighted in each slide and then in the boxes are the recommendations that we have for that; and then following that are the discussions of the background on the area and the background on the recommendation. So this will give you sort of the overview of where we're going and these should match what's in the Word document.

So the first one is the definition of certified EHR technology, and there were two aspects of integration testing that we thought worthy of comment. In the subsequent slides, we'll have a chance to talk about why these were pulled out and what our thinking was around the integration issues.

Okay, so moving on to slide four, so this looks at the definition of certified EHR technology. We like the notion of building up a modular approach that was in 2011, keeping us to the 2014 edition. We further like the notion that providers only need to acquire the technology that matches specific optional parts of meaningful use that they're using and they don't have to buy stuff that they're not going to use. So it addresses what should be a minor, but in some cases what is not so minor an issue for some providers.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

If there's someone who is in an airport if they could mute their phone. Is it you?

Larry Wolf - Kindred Healthcare - Health IT Strategist

Yes, so I apologize. I'm one of the someone's in an airport. I think I'm in a pretty quiet section. So we were concerned, though, that modular brings up issues with integration and that even though vendors could submit many modules under one certification process and have one identifier, that there really was no testing that the elements actually worked together. All we know is they come from one vendor and we recognize, though, the … and possibility of asking everything to be tested against everything else. But there was a concern then around a few areas, we ought to at least float the motion of what could be done, so that's the summary on slide four.

If you go on to slide five, specifically looking at testing, security, safety and usability within the base modules. So clearly doing anything in terms of integration testing is taking on new work for the certification process, and so there could be just increased complexity and confusion around whether this should be tested or not tested, and also given the timing here, do we have enough clarity around what would be in the integration testing. So that all led to some thoughts around we should make it voluntary, but that it might be a useful goal to try and achieve. Then similarly to look at the possibility of integration testing with respect to security for various other components that might be present in EHR to allow

vendors to demonstrate that in fact their pieces work together. So I think that's sort of the highlights on this first piece. What are your thoughts?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, comments or questions?

Deven McGraw – Center for Democracy & Technology – Director

So, Larry, this is Deven. I'm trying to figure out what the ask is of this certification rule, since we're asking for essentially a voluntary process to be established that would test for integration. I guess this is my legal brain trying to figure out how that gets accomplished in a rule that largely mandates requirements that are part of setting criteria for certification that then trigger a meaningful use payment.

Larry Wolf - Kindred Healthcare - Health IT Strategist

Right.

M

Hello?

Larry Wolf - Kindred Healthcare - Health IT Strategist

Yes, sorry, I'm waiting for the announcement to end.

Deven McGraw – Center for Democracy & Technology – Director

Because I mean one could argue that it may be the certification bodies that are hired by ONC to do the mandatory part of certification could establish this as a benefit to their customers without necessarily being required to do so by ONC.

Larry Wolf - Kindred Healthcare - Health IT Strategist

Right, so I think the notion here was how do we bring integration testing into the discussion? To Farzad's earlier comment, this is probably something that they can't suddenly spring into the final rules, because it wasn't addressed in the preliminary rule. So I guess the sense of the workgroup was we'd like to raise the notion that there could be integration testing and that because of both its inherent complexity and the fact that we haven't done it suggests that we needed a very slow ramp-up to get started, which I think was part of the notion around the voluntary; and also that it's likely that even if we had a really good integration test process that tested given a set of modules suggests that they were in fact well integrated with each other. It's not likely that you could do every combination someone might buy. We didn't want to give a false impression that integration testing was included in certification, or if there was any presumption of pre-integration happening if you bought elements from multiple vendors.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Larry, this is Paul. It sounds like there's certainly the spirit of the recommendation and the concern was that there's certainly a risk to providers who purchase if it's even from the same vendor or multiple vendors that it won't integrate and either produce the value or get the meaningful use qualifications. But for the reasons you just mentioned, it almost sounds like this was not going to substantively or certainly reliably produce that best fit. Did I hear you right?

Larry Wolf - Kindred Healthcare - Health IT Strategist

I think that's the case, Paul. We could not envision that there would actually be a thorough integration testing process that would accommodate all the variations somebody might have and how they assemble modules. But nonetheless, because we have this continuing notion of being able to acquire pieces that maybe it was worth trying to look at what does it take to do some level of integration testing and put that out there, so that it is something that people could use if they wanted to, both to on the vendor side and presumably if it's there as a structure, you're right. The certifying bodies could take this on themselves.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Other questions and comments?

Carl Dvorak – Epic Systems – EVP

I would just comment, this is Carl, that there have been certifications for integrated electronic health records through CCHIT for a number of years. In general, I think that the concept of a free market certification makes some sense for vendors who voluntarily want to pursue it, but it is odd to string in usability and safety here as well. I'm not certain how we'd really use the certification process that we have today to get anywhere close to that.

Larry Wolf - Kindred Healthcare - Health IT Strategist

Other comments? So I think we're going to have to almost voice a vote in terms of whether to support the recommendation as presented here with this add a voluntary EHR certification based on security, safety, and usability as part of the meaningful use.

Folks who are supportive of this recommendation? No one is supportive of the recommendation?

Deven McGraw – Center for Democracy & Technology – Director

No, this is Deven. I mean I like the concept of offering to the market a way for integration to be tested on a voluntary basis. I think what I'm struggling with is how this gets promulgated as something that's part of the official certification program versus an add-on that certification bodies could offer with support of ONC, but not necessarily as a mandate.

Christine Bechtel – National Partnership for Women & Families

It's Christine. That was exactly my question. I wasn't sure if you put this in the reg, does it require that everybody has to offer that and should the market really respond to that or it should be a requirement and I don't know the answer.

Gayle Harrell – Florida – House of Representatives

This is Gayle. I think it's difficult to put a voluntary program within a rule. I would question whether that is really the—you can give signals to the market, but I don't know that that's a place for it in a rule.

John Halamka – Harvard Medical School – Chief Information Officer

This is John Halamka. I've just joined.

M

Thanks, John.

Jonathan Perlin – Hospital Corporation of America – CMO & President

And Jon Perlin joined.

M

Thank you.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

This is Paul. I think I'm trouble seeing that this would address the problem that we're trying to solve, which is to reduce the risk of a lack of integration of either a multi-system or multi-modules within a vendor system for having this voluntary program in place, so I'm not sure that—

Art Davidson – Public Health Informatics at Denver Public Health – Director

This is Art. I just wanted to ask a question, maybe if Farzad is still on the phone, given his admonition at the beginning. Is this something that we can address in this passing some judgment back to ONC and CMS? Or is this something outside of what was proposed in the Notice of Proposed Rulemaking?

Farzad Mostashari – Office of the National Coordinator – National Coordinator for Health Information Technology

This is Farzad. I'm not a lawyer, but I think it depends very much on the language and then whether a similar proposal or specific comment was sought on different proposals like that and whether people responded in fact to in that context. I have seen any response to that. … also gets to someone is harmed by this and if they would have cause for concessions.

Deven McGraw – Center for Democracy & Technology – Director

I think that the door was arguably opened, at least partially, this is Deven again, by the decision in the certification NPRM to say that modules would not be required to meet all of the security criteria, but that the base EHR would be required to do so and then the ongoing discussions that were had by a number of workgroups of both the standards and the policy committees about how do you ensure that the security solutions sort of fit together. Certainly a voluntary integration testing approach might be one way of getting at that problem, but that particular solution wasn't raised for comment. So it will be a close legal question. I'm not sure that that alone should preclude us from moving forward, because it will ultimately be the lawyers within the federal government who will decide whether it's out of scope or not. Substance should drive whether this is something we want to say something about.

Carl Dvorak – Epic Systems – EVP

This is Carl. I think in addition the original security process for certification was somewhat flawed having gone through it a couple of times, and I can understand why we'd want to get that fixed. But this now moves into feasability and safety, which are two major areas, and if we're going to create even voluntary program, doesn't that encumber ONC to set up some kind of testing for those who would volunteer?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Let me give an opportunity for John and Jon to comment from an 850 standards perspective if you heard some of the discussion or seen that slide, John and Jon.

John Halamka – Harvard Medical School – Chief Information Officer

No, I had just joined the call, so certainly I was quite familiar with the IE workgroup recommendations and public health standards. What particular issue are you addressing now?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

This is a voluntary base EHR certification to address the problem of … modules and they just won't integrate, so just the value.

John Halamka – Harvard Medical School – Chief Information Officer

So internal integration of multiple products rather than the external integration to other trading partners.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Correct.

John Halamka – Harvard Medical School – Chief Information Officer

So interesting from a standards perspective the committee has generally looked at the interoperability across the organizations rather than interoperability within organizations. In fact sometimes we've said if an organized is black box, it may choose to use closed and proprietary mechanisms within that organization and that's okay, as long as it can ensure that as it does trading partner relationships the content vocabulary and transport standards are just conformant with the national standard. So, Jon P, I certainly welcome your comments, but I think we've tried to keep our scope outside of modules within an organization.

Jonathan Perlin – Hospital Corporation of America – CMO & President

I think you said that very well. I agree.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay. Let me try to get a sense of the group in terms of support or lack of support for this—

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Paul.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

This is Micky. Can I just offer a clarifying comment?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Sure.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Larry, correct me if I'm wrong here, but it seems like we're jumping around a bit in where we think the term voluntary applies. As I recall the certifications option workgroup discussion about this, voluntary would be on the EHR vendor or vendors who choose to participate or get that certification. But the idea was that it would be a mandatory requirement that each of the certification bodies create this certification for integration of modules in the base EHR.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Correct.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

So it's not voluntary for the certification bodies. It would be voluntary for an EHR vendor or vendors as to whether they want to pursue the certification.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Correct. Would people please indicate whether they support this recommendation, please, and those opposed?

M

… fine.

Gayle Harrell – Florida – House of Representatives

Gayle.

Deven McGraw – Center for Democracy & Technology – Director

Deven.

M

Paul.

M

Paul.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, so I don't think it's going to fly, so okay, so this one is not approved by the HIT policy committee.

Larry Wolf - Kindred Healthcare - Health IT Strategist

I thank you. So the comment I was going to add is when the workgroup was working on these, they were very much in the sense that we wanted to provide comments, and as we were heading towards getting

something to actually bring to the committee, it got refined as recommendations. So I think in terms of the workgroup's perspective, having a discussion or raising issues is ….

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, that's fair. We're just bringing consensus ….

Deven McGraw – Center for Democracy & Technology – Director

Yes.

Larry Wolf - Kindred Healthcare - Health IT Strategist

That's right.

Deven McGraw – Center for Democracy & Technology – Director

I actually thought, Larry, it's Deven again, that is was helpful that you had the for and the against on the slide, because it provides some very rich discussion for ONC to consider, even if the for piece of it didn't get the consensus.

Larry Wolf - Kindred Healthcare - Health IT Strategist

Great.

Art Davidson – Public Health Informatics at Denver Public Health – Director

This is Art. This was about some comments back about stage two. It doesn't mean that we couldn't bring this back for discussion for stage three, is that right?

Larry Wolf - Kindred Healthcare - Health IT Strategist

That's correct.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes.

Art Davidson – Public Health Informatics at Denver Public Health – Director

I think it should be on our agenda at some point down the road. It's a good discussion.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

The topic is, yes, so this is something that's produced angst and risk.

Larry Wolf - Kindred Healthcare - Health IT Strategist

Okay, let's move on to slide seven, safety enhanced design. There are three recommendations here. We're going to go through them requiring documentation evidence basically supporting what was in the NPRM, so let's just through the slides.

So the first one on slide eight requiring documentation of evidence that user centered design principle were employed throughout the project development. It seems like a reasonable first step, recognizing that there's still a lot of discussion out there in terms of what makes for a product and the whole variety of different … technologies being employed. So this process recommendation and then supporting documentation, so it felt like a good place to start.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, is there discussion on this recommended comment? It's basically agreeing with the NPRM proposed requirements.

Larry Wolf - Kindred Healthcare - Health IT Strategist

So maybe we should take these one by one and see if we can agree on them and then move on.

W

Are you going to move on each recommendation and call for a vote on each, Paul, or do you want do it in aggregate if there seems to be consensus?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Meaning of the ones in front of us, the two—

W

The two dealing with safety, there's several dealing with safety.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes, go ahead and do the next one then, please.

Larry Wolf - Kindred Healthcare - Health IT Strategist

Okay. So the next one looks at standard quality criteria for software development captured documentation. And again, this is about looking at QA and QA process and looking for documentation that such a process is in use.

W

Aren't we on slide nine?

Larry Wolf - Kindred Healthcare - Health IT Strategist

I'm sorry; I moved to slide nine, yes.

W

Okay.

Larry Wolf - Kindred Healthcare - Health IT Strategist

Or maybe we'll take all of them.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

No, let's take the first two, because I think they're related, but the third one is not quite as related. So the first two are saying as proposed in the NPRM that there would be documentation of user centered design principles being applied, and that there is some software development process used by the vendors and they're essentially a test of test. Are people comfortable that that is sufficient in terms of meeting the spirit and really responding to one, the issue of EHR safety risk and, second, the recommendations put forward by the IOM committee that was commissioned by ONC? Comments?

Deven McGraw – Center for Democracy & Technology – Director

How would this get measured, Larry? It's Deven. Through attestation or what would be submitted?

Larry Wolf - Kindred Healthcare - Health IT Strategist

So my understanding is that documentation that you have a process is what would be submitted to the certification body.

Deven McGraw – Center for Democracy & Technology – Director

Okay, but you could essentially define what that process is ….

Larry Wolf - Kindred Healthcare - Health IT Strategist

At least that's my understanding of what's in the proposed rule.

Deven McGraw – Center for Democracy & Technology – Director

Okay, okay. I think it looks good.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, is there a consensus for moving forward on these two comments?

Gayle Harrell – Florida – House of Representatives

Yes.

W

I'm with Gayle.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay.

M

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Any opposed? Okay.

Carl Dvorak – Epic Systems – EVP

This is Carl and I would agree with it, Paul. The only comment I would make is there a large variety of successful development methodologies for products at different times; and we'd want to make sure that this didn't accidentally morph into a requirement that you wanted to predetermine methodologies and that it should be more or less a publication of what the vendor actually does, so customers can make informed choices.

Larry Wolf - Kindred Healthcare - Health IT Strategist

I think that's what I read in to the NPRM unless anybody else has found something different. It seemed pretty open. It's not simple.

Deven McGraw – Center for Democracy & Technology – Director

Yes, that's the way I read it, too, it's Deven.

M

…discussion within the workgroup.

M

I was just responding to the last bullet point that said it may not go far enough and it seemed like … maybe more.

Larry Wolf - Kindred Healthcare - Health IT Strategist

Well, okay, so you know, I think this is recognizing we're in sort of a dynamic tension of there's some desire to at least for some products to improve their usability and to improve their reliability, so maybe that's what's showing up in that last bullet.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

… this is certainly something I think we need to consider both what the history is with stage two and think about whether it doesn't go far enough when we consider stage three.

W

Right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, do you want to proceed, Larry?

Larry Wolf - Kindred Healthcare - Health IT Strategist

Sure, so this next one was one where there was a fair amount of discussion within the workgroup of exactly how the CSOs function, so this is one of those that either you understood what they did and that they worked within special rules in terms of protecting the privacy of the information submitted or not and so maybe this is a sidebar heads up to ONC in the future, that this was an area that there was some confusion in the workgroup about what actually was being proposed.

So having said that, there was a general sense in the workgroup that being able to collect information about application safety from within the application was a useful thing to do; however, there were also concerns that if you didn't do it well, you could negatively affect user experience and usability. You might be capturing information that wasn't really a safety issue, but people were using it as a general, hey, I've got a question about how something is working or have a concern about something and questions about how this might tie into other event reporting applications that a provider might have for other kinds of safety issues. So maybe this is one of those it all depends on how you get the details right, but the notion of having a standardized file that would capture stuff that might then be useful for a variety of purposes seemed like a good thing to pursue.

Gayle Harrell – Florida – House of Representatives

Larry, this is Gayle. Was the any discussion on the liability issues along this line?

Deven McGraw – Center for Democracy & Technology – Director

This is Deven. I worked on this legislation, so they've got liability protections for data sent to a patient safety organization under the federal infrastructure.

Gayle Harrell – Florida – House of Representatives

Okay, I just wanted to verify, thank you.

Jodi Daniel – ONC – Director Office of Policy & Research

I can confirm that, this is Jodi.

Gayle Harrell – Florida – House of Representatives

Thanks, Jodi.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Larry, this is Paul. Under the second bullet where it says the workgroup favors this proposal, it talks about reporting events. It says common formats are available. Did the group talk about requiring the reports to be compliant with the common format? So there's AHRQ sponsored common format for safety reporting, which includes a section on HIT related safety events, so it's not just a phrase. It's actually a term of art is the quote standard for this kind of reporting. So would you require it?

Larry Wolf - Kindred Healthcare - Health IT Strategist

So I guess this may be a place where we want to decide in terms of what we did or didn't know about standards, and so I understand that's a common format that is capital C, capital F common format. I haven't looked at it with an eye towards how machine-able is it and if you're looking to capture information for submission to CSO, how well it would work, I just don't know the answer to that. I think it's very reflective in some ways of the challenge the workgroup has as not necessarily being experts on standards.

John Halamka – Harvard Medical School – Chief Information Officer

So I am unaware, this is John Halamka; I'm unaware of any standard for the common exchange of safety events that has been adopted widely by any manufacturer. Certainly I've seen proprietary products that do it. I've seen people use such things as spreadsheets and text files, but Jon P, have you ever heard of a common format for PSO reporting?

Jonathan Perlin – Hospital Corporation of America – CMO & President

Not at this point, no.

John Halamka – Harvard Medical School – Chief Information Officer

I know that the PSO at Harvard is inventing its own common format this year.

Larry Wolf - Kindred Healthcare - Health IT Strategist

So John, when you say that are you using lowercase C common format or you using that they're taking the actual common format and creating a technical spec for it.

John Halamka – Harvard Medical School – Chief Information Officer

It is a lowercase C and that is certainly many organizations have worked in a local level to try to exchange events, but I have not seen any commercial efforts to integrate into products an uppercase C format and so I would call this the low maturity, low adoption from a standards perspective.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I think what we're saying then as a workgroup for the policy committee is this felt like a good thing to have, but I'm hearing sort of consensus around, so we probably don't actually have a standard that we could apply at this time.

M

Correct.

M

I wonder if we need to do a little due diligence. It's certainly true that there's not one that's widely adopted, but I don't know the exact stage, but I think common format is getting mature, that's capital C, capital ….

John Halamka – Harvard Medical School – Chief Information Officer

Certainly I can look into it further, but in the various local deliberations that we've had around the Harvard PSO and in the standards committee, it is not something that has come up as something that has had any degree of adoption or there isn't great knowledge about it as a standard implementation guide.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, I wonder if there are some hedging words that—ONC is listening in on this conversation, so for example, if the common format is in a standard form and could be used in 2016 then it would be their judgment of whether to make it required. So would we be comfortable saying if there is a standard for communicating HIT related safety events that should be used? Otherwise what the recommendation would say is you need to report something and that wouldn't be a big event or anything. Do you see what I'm saying?

Larry Wolf - Kindred Healthcare - Health IT Strategist

So qualifying it to say that as a standard implementation guide is available, then that should be used. This is low maturity, low adoption at this point.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Right, so we're four years away from stage two.

Carl Dvorak – Epic Systems – EVP

Paul, this is Carl. I think it'd also be important to have someone review the PSO legislation in context of a provider, the protected conversation and also the vendors involved. My understanding was that disclosure to a PSO was still protected from a liability perspective. But if you disclosed it possibly to your vendor, then that disclosure would not be liability protected.

W
That's correct.

Carl Dvorak – Epic Systems – EVP

Therefore we may create an environment where people choose to not disclose for vendor to gain a liability coverage protection, which could adversely affect safety of the EHRs overall, and we may need to revise that legislation to make it appropriate for this kind of situation because it turns out it wasn't actually built for this.

W

That is a major concern.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I think the analogy is the same for a device manufacturer, for example.

Deven McGraw – Center for Democracy & Technology – Director

Yes, but it's a good question. Jodi, do you know the answer to this. This is Deven. I knew the legislation specifically created protection around data that gets sent to a PSO for safety analytics purposes, but I'm not sure if that data gets sent elsewhere that the same protections would apply and I suspect they would not.

Jodi Daniel – ONC – Director Office of Policy & Research

I think that's right. I think if the same information is sent elsewhere that the protections to do not apply. That's my understanding, but I'm not a ….

Deven McGraw – Center for Democracy & Technology – Director

I wonder if you could put your vendor on your PSO.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

There are some vendors who are PSOs.

Jodi Daniel – ONC – Director Office of Policy & Research

Yes, there are vendors who are PSOs.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes, unfortunately the PSO, it was fairly loose criteria, so there's a number, there's so many things to choose from, there are so many PSOs to choose from, that it's actually one of the problems. Is someone familiar with the FDA rule, so when you report an adverse event to a drug company or a device manufacturer and then that goes on somewhere, wouldn't that be the analogous situation? How is that protected or not protected?

W

What was that?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I don't know.

Jodi Daniel – ONC – Director Office of Policy & Research

I don't know enough to be definitive on this. There is some information. I think some information is public and some of it is protected, but I don't know the specifics.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

It's a good question, but right now the comment is on whether EHR should facilitate the reporting of potential safety then to a PSO which gives a protected reporting mechanism. While the other question is of interest and it doesn't address what we're trying to do here, which is one of the issues is the potential

for EHR safety related events. One of the problems is we can't find out about them, because there's not a common way of reporting it to a place that would aggregate and analyze. So this is trying to be responsive to one of the recommendations from their own committee and this is a facilitator. So what this is saying is stay with the proposal, but having EHR be able to report potential safety events to a PSO.

M

Actually, I don't remember, Carl, the EHRA had a … PSO reporting of safety events. Was there any interaction between that in this context?

Carl Dvorak – Epic Systems – EVP

Yes, we studied this pretty extensively and it seems like there as some gaps that could have unintended consequences. There's certainly for lowercase safety organization, I think we generally would be supportive of a built-in reporting format. There are good organizations like the Institute for Safe Medication Practices that seem to protect reasonable confidentialities of copyright while still sifting and winnowing out the essence of what could be done to improve software work to be done to improve convention and usage patterns and things like that. So I think in general the association has been supportive of a standardized format for submission through a patient safety organization small p, small s, small o. But as we talk about the Patient Safety Act of 2005 and such, I think there we need to do some additional work before we make requirement that it goes to a formal PSO.

M

In terms of the common format, capital C, capital F, was any deliberations for the EHRA—

Carl Dvorak – Epic Systems – EVP

I think the mood is generally supportive of a standardized common format.

M

Rather than a standardized common format multi-small s that I think John Halamka was asking about the specifics of the arc FDA etc. generated those comments, thoughts, … the capital C, capital F, common format for reporting of adverse events.

Carl Dvorak – Epic Systems – EVP

I'd had to double check to be certain, and so let me do that and follow up.

Larry Wolf - Kindred Healthcare - Health IT Strategist

So Paul … I'll send you the latest implementation guide from AHRQ on this and a question for … and NQF, what is his assessment of maturity and adoption, it is the CDAR2 standard using XML, that is specific to PSO data submission, so I would say it generally follows the flavor of what it is we said in the standard committee should used for document type submissions. We just are not seeing any implementation in production of it.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So let try to summarize what's being proposed for consensus, which is just to agree with the NPRM recommendation that EHRs be able to submit patient safety events to PSOs; and I'll check whether this group agrees with a conditional statement that where a common standard is available and could be adopted that that would be a requirement for the safety reporting. Have I captured that accurately as a proposal? So do people on the committee agree with that sentiment?

W

Yes.

Deven McGraw – Center for Democracy & Technology – Director

Yes; it's Deven.

M
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Disagreements? Okay, so Larry, we can go forward.

Larry Wolf - Kindred Healthcare - Health IT Strategist
Okay, let's go forward onto slide 11. So moving on clinical decision support, so I have to say I don't remember exactly where we came on and where things were comments and where things were recommendations, so let's just go through these and see how they shake out.

So this is looking at it's a shift in language in the NPRM of clinical decision support interventions versus rules as a more broad and robust definition. Then we had a lot of discussion about in focus and this might have been another place where we may have misunderstood the intention of ONC, or whether that was being suggested as something that could be done and if you use that kind of look-up, you can go by the standards, or if this would proposed as the way to do some system support.

M
I think before we have too much discussion of this, and also being mindful of time, there was a pretty robust discussion around InfoButton and its potential applicability for the standards committee, so as John, maybe you want to mention that or you may just want to where it's a standard's issue defer to that conversation.

John Halamka – Harvard Medical School – Chief Information Officer
Sure, the gist of the conversation is that InfoButton is not a decision support standard. It is actually a quite fine mechanism to deliver educational materials, but extraordinarily challenging given complexity around patient characteristics to use that standard to provide a patient specific customized educational material at the point of care. So the standards committee said we will not make a recommendation that the InfoButton should be used for clinical decision support that is patient specific and that certainly we concur that it should be trialed and piloted in the industry for educational materials, but not CDS.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Good, thank you, John.

Larry Wolf - Kindred Healthcare - Health IT Strategist
That's great, thank you. Now maybe we can blast through the details slides and maybe we get back on track with the time. So slide 12 was some of our discussion around use of intervention versus rule. Then you can see where we quickly sort of dove into where's InfoButton sit in this, so I'm glad we can set that aside. We're sort of reiterating on slide 12 some of the things that were suggested, the combination of one or more of the following … etc. and a notion that you can get bibliographic information when a rule was triggered, so you'd have a way to evaluate the rule.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Is that a specific recommendation that the actions that they become mechanism and certification for keeping track of the firing of the rules and what happens?

Larry Wolf - Kindred Healthcare - Health IT Strategist
Yes, it was. There was a sense that when a rule is invoked, that there's a way to find out what that rule was and what the documenting support was for it, recognizing, though, that sometimes all of this happens in a more subtle way, sort of behind the scenes and it may be indistinguishable from work flow. It's not always that you get an alert that says warning, these two drugs interact and you can look at the details around the interaction. Sometimes clinical decision support is much more subtle and they have to do with how notification escalates within an organization, or it could almost be anything really looking at this range of clinical indicators could be brought together in lots of ways that could improve the care, but it might not always appear to the user as a decision.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So while that's true, we should probably answer a further question in terms of are we suggesting that certification criteria, that each art be capable of recording the actions taken as a result of the CDS. It could be of a rule. It could be the linkage between that and a change in the order, like it's either a change or ... of an order. Is that included somewhere in here?

Larry Wolf - Kindred Healthcare - Health IT Strategist

So I think that notion of capturing the user's action was not one that we talked about at the workgroups, although it certainly is an important and useful thing to know.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So does your next slide change topics or do we need to discuss this?

Art Davidson – Public Health Informatics at Denver Public Health – Director

Paul, this is Art. May I just add, can we add bullets under this each one, or any combination of the following? Is this all that we are suggesting, because clinical decisions were to apply to immunizations, too. Is that embedded in the medication? I'm just trying to understand whether we think that that's not part of clinical decision support.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I think this list came out of NPRM. Am I correct? Maybe the ONC people can verify that.

Steve

Correct, this is Steve.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So I think this is not included in immunizations as it's stands, but you might look at some recommendations. This was sort of a definition of "patient context." I can see where you're coming from. They either did or didn't get a ….

You know what, so maybe the way to accommodate that would literally just be procedures, because all those immunizations would be procedures and had they had, either they have or don't have would react as part of trigger.

M

Right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So maybe that actually is one, is a useful suggestion.

M

Thank you, Paul.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Do you want to go ahead, Larry, and then we'll sort of come back and add any addendums perhaps?

Larry Wolf - Kindred Healthcare - Health IT Strategist

Sure. So moving on to slide 13 is really more discussion in which state to focus on InfoButton. I think we already heard comments from the standards folks that InfoButton was really not intended to be a central … structure. It's really a way to get patient information or information that's passed on to a patient based on their admissions. So ultimately the standards committee concluded that a functional description of what it is you want to do would be better than specification of InfoButton, and we said InfoButton is a fine standard, but it is certainly optional for the kinds of purposes that we've been describing.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

In your last bullet, it says propose a broader certification criteria for the five examples of decision support and at least one set of decision support software build tools. Is the implication there that you're adding a requirement to that certification criteria? I'm not sure why, the whole purpose of the attributes of decision support intervention is to be flexible in how you shape orders and decisions. It looks like you're adding that you're prescribing something, what you called software—

Larry Wolf - Kindred Healthcare - Health IT Strategist

Yes, I think we could probably back off of this. I think this was to accommodate what were we supposed to do with InfoButton, and we were saying, well, if we relegate it to one of them at least we're simplifying things, but I like relegate to none of them and saying it's there to use it, but it may not be appropriate.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, I think the way John presented InfoButton, this InfoButton issue is it's clear and probably makes many of these points moot, which is what you said.

Okay, so I think so far, the two things that have been raised in addition to what's been presented here is one is additional procedures as part of … context and the other, these are up for discussion, and the other is whether an EHR should record user consequent actions in response to a specific reported intervention. Do we have any comments about those two proposed additions or other additions or questions or comments?

So let me see if there's consensus to add procedures to the patient context. Is there support for that or is there opposition to that?

M

I think we had a good example with immunizations on why it would make sense to add it.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

How do people feel about that?

M

Would immunizations—can we clarify what's included in the scope of a procedure?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

No, what we're saying is procedures would include the example that was raised by immunizations, so adding procedures to the patient context is the way to the proposed solution.

M

Some might consider an immunization a medication in certain context.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

But then we've got them both covered.

M

Okay.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Is there consensus about adding procedures?

W

Yes.

Deven McGraw – Center for Democracy & Technology – Director

Yes, I have no objections, this is Deven.

M
I agree.

W
…

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay, the next suggestion was adding user consequent actions as something that's recorded in response to CDS intervention. Discussion of that point? Okay, so are people in favor of that?

Deven McGraw – Center for Democracy & Technology – Director
This is Deven. Can you explain the purpose of doing that, because I could see how that information could be misused, but there's probably something very useful for it.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. So the idea like most of these "interventions," you want to know whether it has made an impact and is that positive or negative or neutral. So one of the things that we generally do not have access, because while we built, let's say, you build 5 rules or you build 100 rules, which ones are having a positive impact. The only way you'd find out is how did people react. In fact in studies, this is one of the ways we found out that the current use of drug interaction databases is largely ineffective and potentially distracting, in other words, a very high false positive rate.

W
Right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
It turns out—

M
… brought up in the context of alert fatigue.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes.

Deven McGraw – Center for Democracy & Technology – Director
Right, but that kind of report would be on an aggregate basis, right, not whether Dr. Jones was ignoring decision support alerts.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Well, the information is there, so some of the interventionists have already said like if you're going to turn down this alert, tell me your reason why, most of which are legitimate. It's just it's used in a couple of ways. One is that it's a very legitimate way of improving the alert and the other is to understand why something was not …. So I think going to the question you're asking, Deven, is ultimately if people are going to be accountable for their actions.

Neil Calman – Institute for Family Health – President & Cofounder
This is Neil. This is the ability for systems to be able to report on that, correct?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
They capture that information and then ….

Neil Calman – Institute for Family Health – President & Cofounder

It doesn't necessarily mean that the systems are going to capture it on every decision support that's entered, right? I mean, is it a reporting capability, or is it that they'll be reported automatically on every decision support that's ….

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

No, no, no, you're right. Capture the action so in generating you're going be using this in aggregate to understand where the good interventions are and to improve those rules ….

Neil Calman – Institute for Family Health – President & Cofounder

Right, … correct, it could be used in the opposite way, but I think I would be in favor of this.

W

Okay.

Deven McGraw – Center for Democracy & Technology – Director

Neil, if you are, I am, too. It's Deven.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So we've got two votes for.

W

Yes I see some potential misuse of that and I see a lot of my ability issues with it.

Deven McGraw – Center for Democracy & Technology – Director

Yes, right, but it's the capability. I think Neil made the point that providing the capability is not directive of how it gets used and each institution would have to make that decision.

W

Correct, okay and then … with the capability.

Carl Dvorak – Epic Systems – EVP

Deven, this is Carl. Does that imply that it would basically be turned off by default and people would choose to turn it on, because once it's captured behind the scenes, like what a provider did in the face of an advisory, it is discoverable. So is the implication here you have a capability under certification, but no obligation for an organization to actually turn it on?

Deven McGraw – Center for Democracy & Technology – Director

That's the way I'm interpreting it. This is Deven. It's sort like the encryption functionality on your EHR.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes, I agree and unless future regs or guidance ... between on and off, but right now we're just talking about capabilities.

Neil Calman – Institute for Family Health – President & Cofounder

I would see it as more granular. I don't think we would be turning it on for every decision support or off for every decision support, but it's capturing the data and giving us the capability of looking at the efficacy of these supports and I think that's critically important.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I agree. Okay, I've heard a number of yeses, anybody opposed to that addition? Okay.

Art Davidson – Public Health Informatics at Denver Public Health – Director

This is Art. I'm voting in favor.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, good. Okay, I think we're ready to proceed. Are you still there, Larry?

Larry Wolf - Kindred Healthcare - Health IT Strategist

Yes, I'm still here. You're hitting me right in the middle of an overhead page. So we're ready to move to slide 14 on other health care setting.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Correct.

Larry Wolf - Kindred Healthcare - Health IT Strategist

Okay. So this was a pretty broad question about what should we look at for other health care settings and how to relate to them. Overall we recommended that there should be, we want to encourage exchange using consolidated CBA as our go-forward standard for summaries, and that there is some experience of voluntary certification criteria that's setting specific and there's been some uptick on that.

So let's move on to slide 15. The intention here was to put some broad groups out there that get a lot of attention as other providers that are ineligible for the EHR incentive program generally under the umbrella of post acute and long term care and also under the behavior and mental health umbrellas. Then there's a whole mess of other settings where some amount of health care is provided and some amount of medical record might be kept, but also sort of falls into a broad other categories. So none of these lists were meant to be comprehensive, and also none of these were meant to say that an eligible provider couldn't be providing outpatient services in one of these settings and as … getting into …. So we're trying to distinguish the setting from the individual providers.

And then sort of an educational piece that there's really a mix of characteristics among these. There's often a shared care of some kind going on and making more important the ability to coordinate care than in some other settings. So many of these settings don't offer the full suite of services that a typical acute care hospital offers, so while they may be housing an individual and providing care, they typically won't have an onsite lab. They might not have an onsite pharmacy, so they're relying on other providers to bring other ... providers to bring services in. They may not have a physician onsite full time and things like that, so the level of coordination increases in these settings.

I guess another relevant piece is some of these settings have mandated electronic assessments, which creates sort of interesting questions as we go forward with automating the care in various settings is creating standards for those settings of standards of assessments. That's really sort of another—going in another direction.

So moving onto slide 15, so we recommended that care summary exchange was an important thing to do and that as in some of our discussion around how to count where documents go, where summary documents go, that we want to make it easy for ineligible providers to get these standardized documents, and that it might be valuable to identify a minimum set of certification criteria necessary … the state and the standard states exchange. It looks like the way the NPRM is structured that the exchange related criteria are pulled together into one piece, so this is more sort of a guidance. But as we look at enhancing the criteria over time that we recognize that they might not be used only for meaningful use. They might be used more broadly as a way to identify standards that would allow other providers to engage in information exchange.

M

At this point, … that's part of the standards committee decision around the governance RFI, which we will designate in a couple weeks' time.

Larry Wolf - Kindred Healthcare - Health IT Strategist

So moving on to, so the next one is voluntary, maybe we should just look at this piece right here. So really we want to encourage the use of this care summary for exchange that has real value in these settings and that look at their certification criteria to be clean, so that if some provider of some software vendor offered a product that was intended for one of the ineligible providers specifically addressing the interoperability around exchange or … or validated CBAs that they could have that piece tested and that it wouldn't put extra burden on them to test things beyond the documents in the exchange rules around it. Is there any discussion around this one?

Colin

This is Colin. I apologize if it's already come up as a topic, but would eligible professional eligible hospitals transmitting a document to one of the organizations that sit on this sort of health care settings qualify as a transition of care?

Larry Wolf - Kindred Healthcare - Health IT Strategist

So I think that was the intent from the policy committee's discussion back in May, so they would qualify.

Colin

Okay, thank you.

Deven McGraw – Center for Democracy & Technology – Director

Larry, this is Deven again. Are we asking for a different set of standards for continuity of care document, or is it's the same ones we requiring, but just suggesting that an ineligible providers be able to get a system that meets those standards?

Larry Wolf - Kindred Healthcare - Health IT Strategist

So it's a … so the meaningful use and certification criteria are tightly bound together. There's been a round of lumping that's been happening with the stage two. So the concern here is that we want to encourage exchange, and we want to encourage vendors who aren't offering a broad product, because the market it's going into doesn't need the certified EHR, but they want, a provider in that space wants to buy something that they have some assurance will be able to handle the standard document; that they'll at least be able to receive it and they would be able to send it. So to try and stay clean if those certification criteria get bundled in various ways, that the things that relate to the production and the receipt, the incorporation of these documents stay focused on just that piece or just those pieces.

I don't know, Deven, am I clarifying?

Deven McGraw – Center for Democracy & Technology – Director

Yes, no, I am, I'm just trying to figure out whether there's, it's the same sort of set of questions that I had for the voluntary certification that we sort of began this discussion about, like why there isn't sort of a market driven reason for one of the certification organizations to just provide this service versus having it be some sort of mandate that would come through the certification process that has largely focused on mandatory criteria tied to meaningful use. The idea is to make those kinds of services available outside of the meaningful use infrastructure, but since the infrastructure is there, what's holding folks back from providing the service.

Larry Wolf - Kindred Healthcare - Health IT Strategist

So I'll give you the counterexample from stage one. Stage one allows for two care summaries, a CCD and a CCR. And so I know of at least one vendor who sells into the post-acute space who got CCHIT certification for their products, which only require that they send and receive CCDs, but did not get ONC certification as a module for interoperability, because the ONC requirements also included CCR as they should have, given what stage one said. But because those two features were bundled, they didn't get the ONC certification and they're now having to explain to the marketplace why they don't have ONC certification.

I'm looking to unbundle—I want to make sure that we keep the exchange pieces, the certification clean, so that as vendors outside the state or even inside the state get stuff certified, that they can say this piece says the care summary and this piece send to the … and we sent to that piece and that that could an isolatable module.

Deven McGraw – Center for Democracy & Technology – Director

Okay. Thanks, Larry. I totally get your point. I'm just troubled by it's so early I'm trying to wrap my mind around how you do mandate voluntary certification.

Larry Wolf - Kindred Healthcare - Health IT Strategist

Right, right, so what you're doing is, you're using a mandatory process for some.

Deven McGraw – Center for Democracy & Technology – Director

Right.

Larry Wolf - Kindred Healthcare - Health IT Strategist

Right, and you're saying if you are outside of the scope of a mandate, but have market value to you and your customers in having your product certified to some of the criteria that's available and the certification would actually be meaningful, that limited certification would still be meaningful for your market.

Farzad Mostashari – Office of the National Coordinator – National Coordinator for Health Information Technology

This is Farzad. What's interesting to me is what you're saying, and this is an interesting angle on this is we don't necessarily need certification of long term care, for example, products, for their long term care functions. But what we want is the cross-certification as it were that the interoperability certification because what we really need is to focus on the interoperability between the long term care product and the inpatient, outpatient … rather than being certified.

I guess what I'm wondering is that the certification requirement and the test for certification then would be, should be, identical, and in essence why couldn't we actually say even become a module, become certified as an interoperability module?

Larry Wolf - Kindred Healthcare - Health IT Strategist

Yes, that's exactly right and so their only request is that the actual testing is specific to the interoperability piece.

Farzad Mostashari – Office of the National Coordinator – National Coordinator for Health Information Technology

But I guess what I'm saying is can't a product that's selling into that space today even if they don't plan on selling to the inpatient or outpatient electronic health record marketplace, couldn't they go to any of the accredited certification bodies and be certified as in a module that only does interoperability piece.

Larry Wolf - Kindred Healthcare - Health IT Strategist

Yes, they could.

Farzad Mostashari – Office of the National Coordinator – National Coordinator for Health Information Technology

Okay.

Larry Wolf - Kindred Healthcare - Health IT Strategist

Yes, they could and some of them have, they've had modules certified to ONC criteria.

Farzad Mostashari – Office of the National Coordinator – National Coordinator for Health Information Technology

And then presumably more could be encouraged.

Larry Wolf - Kindred Healthcare - Health IT Strategist

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Is the certifying body required to test anybody who wants to be?

Larry Wolf - Kindred Healthcare - Health IT Strategist

I don't think there's any constraint on who's tested and what they're going to do with the result, other than the constraints of how you're allowed to advertise it.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So in that case, what Farzad is suggesting is this is already possible. It's already in place in a sense.

Larry Wolf - Kindred Healthcare - Health IT Strategist

So I guess this is saying let's not muck it up. Let's not bundle something together that may get the bigger piece. So here will be an example that might be a place where, so we're looking at what does it mean to incorporate a CCD into your EHR, right? So I can receive it and I can capture it and I can preserve it. Is that sufficient for me to check off the box saying okay, my product is now good enough for me to participate in exchange, or does it now say, well, wait a minute, we said that it's no longer good enough to just receive it, we want you to do a reconciliation process around the elements of that care summary and that you should import it as discreet data.

So I think that that's really valuable, but are we going to be then forcing ineligible providers to take on more work, even though it's good work, and that their products—so I would want to separate those two pieces. I want to separate the ability for you to receive it and have it and have it be doable from your ability to do a more complex incorporation of the data elements.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

One of the questions that came up was does a transition to an ineligible provider count to the denominator of transition. The answer offered was yes, but then how do you decide which ineligible provider to count in the denominator, only those who can receive it and are willing to, correct?

M

That's an area of discussion, but I think a denominator for a hospital for … for example might be all discharges, right?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

That's because they have the option currently of providing paper transition documents. When we go to electronic and there's a percentage like you have, what counts as the denominator if you allow ineligible providers to also be part of that.

John Halamka – Harvard Medical School – Chief Information Officer

Paul, this is John Halamka. Unfortunately I have to drop off, but I would just tell you for the rest of the slides, I would certainly concur that data portability when you get to that section is not going to be adequately supported by the current standards and therefore one should reflect what the true goals of that effort are.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

All right, thank you.

John Halamka – Harvard Medical School – Chief Information Officer

Thank you.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Which I take as a warning bell for all us is that a little under a half an hour left and we need some public comment time as well. So can we wrap up this discussion? It sounds like we recognize that any vendor could apply for a modular certification?

W

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

And that that has some value in the marketplace.

M

Yes.

W

Yes.

M

That's fine.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay.

Larry Wolf - Kindred Healthcare - Health IT Strategist

Okay, voluntary, there is a voluntary process in place. CCHIT has one. It had a few vendors go through it. I think that there's no final verdict yet on whether this is of value to them or not, but it's out there and it seems to be happening to some degree. Maybe there's another point worth making, the various specialty areas, and I use specialty just to include some of the traditional physician specialty areas, as well as these other providers, have seen value in working with HL-7 on functional models and profiles, as well as working in CCHIT on specialty certification. I think that there's some value seen in being able to say here are the things that make an EHR useful in a particular niche.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

But what's the specific recommended comment then?

Larry Wolf - Kindred Healthcare - Health IT Strategist

So I think that we're commenting that there is voluntary certification happening and it seems to have some value.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay.

W

It sounds good.

M

Okay.

M

Okay.

W

Sounds good.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Are you on to accounting for disclosures?

Larry Wolf - Kindred Healthcare - Health IT Strategist

I'm sorry, I was on mute. Let's move to on to accounting and disclosures, yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay.

W

You've got a lot of text on this slide, Larry.

Larry Wolf - Kindred Healthcare - Health IT Strategist

Yes. We do have a lot of text on this slide. So I think that the base comments here are that we don't yet have final rules on the accounting of disclosure, so building certification criteria seems a little bit iffy, given that we don't have the final rules around what it is we're trying to have software support. There are concerns that audit logs, depending on what the definition of disclosure is, audit log doesn't capture intent. So just because you know someone did something, you don't know why they did it, and you may not have all the context about their relationship with a patient or in an emergent situation happening. So yes, audit log tells you someone looked at something or someone added something to a record, but you don't always have the full context. So if we're relying on audit logs as the source of disclosure or the mechanism for accounting for disclosure, it might be problematic because it might not have enough information for you to know if it were a disclosure.

Then there was the example that Intermountain Healthcare provided thousands of pages of audit logs if that's what was really intended that maybe that was overkill for an accounting and disclosures report.

Deven McGraw – Center for Democracy & Technology – Director

So, Larry, you concluded that you would, this is Deven, that you would leave this, keeping that this current criteria optional, as long as there isn't yet a long term plan for how to address how this is going to get implemented from a policy and technology standpoint is what I read.

Larry Wolf - Kindred Healthcare - Health IT Strategist

Yes.

Deven McGraw – Center for Democracy & Technology – Director

Yes, this is Deven. I would totally support that. This is just one where there's got to be, sort of concurrent discussions from the technology and policy side about what's possible and where the technology needs to go in order to make feasible a better type of report for patients than we could possibly generate out of current functionality, so.

Gayle Harrell – Florida – House of Representatives

I would concur with Deven. I think this is extremely an important area for patients to be able to—and we need to make it ….

Larry Wolf - Kindred Healthcare - Health IT Strategist

I'm sorry, you got cut off. We need to make it what, Gayle?

Gayle Harrell – Florida – House of Representatives

We need to make it as functional as possible, … happen.

Larry Wolf - Kindred Healthcare - Health IT Strategist

As useful, right.

W
Yes.

Gayle Harrell – Florida – House of Representatives
Be useful, yes.

Larry Wolf - Kindred Healthcare - Health IT Strategist
Okay, so you're basically saying do not have an additional certification criteria on this, but—

Deven McGraw – Center for Democracy & Technology – Director
It's optional right now and it should stay that way, I think is what they're saying.

W
Exactly.

Larry Wolf - Kindred Healthcare - Health IT Strategist
Okay. Any disagreement with that? All right.

Neil Calman – Institute for Family Health – President & Cofounder
Deven, this is Neil. Are you saying that it's optional whether to be able to produce it at all, or it's optional, the format is optional?

Deven McGraw – Center for Democracy & Technology – Director
No, the standard itself would be optional, so again, this is about the high tech change to the current accounting of disclosure rule, which has been proposed to by the Office for Civil Rights to be a report of access to an EHR. But as Larry pointed out, that doesn't necessarily capture the type of information that patients are likely most interested in receiving and would generate volumes and volumes of paper. So the idea is that there ought to be a better technical functionality to generate the type of report that was envisioned by the high tech language and we just don't have it yet.

So there is an optional certification criteria that's been in place since stage one. I don't think many vendors have implemented it, and unfortunately, we don't have a good answer about yet about what they should implement. And so leaving the criteria as it is is the best possibility, or removing it altogether, but certainly I'd just put keeping it optional. I don't think anybody is pursuing it.

Neil Calman – Institute for Family Health – President & Cofounder
All right, thank you.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay, I guess we can move on.

Larry Wolf - Kindred Healthcare - Health IT Strategist
Okay, disability status, so there are three chunks here. One is shown as a comment and then two recommendations and so let's move on to that. So the …master comments about disability status, probably the first thing is we're saying is while this is valuable as concept for looking at health disparities that the clinical view of this is that disability is not the way to look at it, but functional status is the way to look at it, and what's someone's functional level. As some of the flags or descriptions that are used in the questionnaires that have been developed by HHS for self reporting, they're probably not sufficient to actually provide useful information for clinicians.

So that's extended again on slide 22 with this notion of there's a new emphasis on improving care and tracking disparities. There's a concern that the notion of a disability or a functional status as a demographic tends to shift people's thinking that this is somehow part of the registration process, but that that's probably not the best place to put it.

So we identified at least four different areas, one of which is registration could be patient reported information to build a clinician assessment, that they're actually assessing some specific functional ability or it could wind up on a problem list of some form that identifies this. In HL-7 there are various ways of addressing these in terms of formal coding of problem lists or assessments. And if the disability would be included in the care summary and other transition to the care documents, where it's really a focus more on capturing the information that you need to provide good treatment in patient centered care and less disability access issues actually be a secondary piece here.

So that's sort of the conceptual comment and then there's the recommendation that there seems to be a lot of work happening right now in terms of the standards for describing functional status and that those don't look like they'll be settled down in time for a stage two final rule, so we are recommending those to stage three process.

So maybe I'll take a pause there because those all sort of hang together, any comments or discussions about those?

Neil Calman – Institute for Family Health – President & Cofounder

This is Neil. I'm just trying to think about it. It just seems to me that if we—I understand that this a standards change, but if we wait until there's standards for everything, we have years of not capturing information that's pretty critical, not just for how people are treated, but also what their ability is to use electronic health record access themselves and how we facilitate that process. So we're basically saying that we're not going to—what are we doing to encourage, I guess, a standard to be developed, or what are we doing interim is a better question. What do we do in the interim? Like shouldn't we say that there needs to be a way to capture this information even if there's not currently a standard to capture it?

Kevin Larson – Hennepin Co. Medical Center – Associate Medical Director, Informatics & CMIO

This is Kevin Larson from ONC. In the context of the clinical quality measures around functional status, we're actually going to have blank codes and SNOMED concepts for those functional status items in time for the MU2 program, but they're just specific to the measures, the functional status measures that are in the MU2 program.

Larry Wolf - Kindred Healthcare - Health IT Strategist

In that additional information, maybe that addresses Neil's concern, because I agree, it would be good to start.

Art Davidson – Public Health Informatics at Denver Public Health – Director

So this is Art. I have a question about this. It sounded like you were saying, Larry, that maybe we framed this wrong with the disability status and we should say something more along functional status. Is that the recommendation? And then secondly, this dual emphasis on improving care and tracking disparities, is it that or is it more about getting patients more involved in contributing to the clinician's knowledge?

I don't know if the second part of this dual emphasis is really the right thing here. That's what I'm—

Larry Wolf - Kindred Healthcare - Health IT Strategist

Sure, so this is the discussion in the workgroup. It doesn't mean it's definitive, but it seemed like there a lot of discussion out there outside the workgroup when we started just looking at, well, so how are disabilities being used and what is that terminology and there were references to some work that HHS is doing in terms of surveys, and they talked about disparities of access and things like that. They seem like they weren't really capturing what could be a very valuable clinical thing, which is knowing the patient's actual status. Do you need help getting something done? Can you do it on your own or not? Yes, that could be an area of patient engagement and it certainly could inform decision making and it becomes very important in setting for someone is receiving care for more than a couple of days or just an outpatient to make sure that the support services they need are in place. So it's very valuable information clinically and I think it does engage the patient.

Art Davidson – Public Health Informatics at Denver Public Health – Director

Yes, I totally I agree with you and what you're doing here. I'm just trying to figure out if we have it worded right; that's all.

Larry Wolf - Kindred Healthcare - Health IT Strategist

Okay. So given this new information about what coding would be available, my sense is the workgroup actually, had we known that, would have said well, then, let's go for it. Let's use the functional status as it's being defined in these quality measures and use that as a base to build on.

Farzad Mostashari – Office of the National Coordinator – National Coordinator for Health Information Technology

This is Farzad. Let me ask Kevin a clarifying question. Is the presumption that those SNOMED codes would be retrieved from the problem list?

Kevin

No. If the presumption is that they will be part of the functional status assessment tool that's used in the context of the measure. So for example, we have a measure around a functional status for a total knee and total hip surgery. There will be a collection of functional status pre-surgery and then again a collection of functional status post surgery.

Farzad Mostashari – Office of the National Coordinator – National Coordinator for Health Information Technology

Using which coding system?

Kevin

They're using, they're allowing for more than one and the way that it works is that the serving instrument will become a LOINC style with code and then the result will be … so that SNF12, for example, would be a LOINC concept, which it already is, actually, but the—

Farzad Mostashari – Office of the National Coordinator – National Coordinator for Health Information Technology

So it's either, I just want to add one sentence. It sounds like these are quite specific …

Kevin

They are specific to the particular quality measures, although they're leveraging the SMS6 quite a bit.

Farzad Mostashari – Office of the National Coordinator – National Coordinator for Health Information Technology

Right, I know that if captures what it was hoping for in having a measure of the disability, or I don't know. Maybe it does in terms of you know, what was the survey that relates to whether it's how well the person can walk or go up stairs or whatever. I don't know if that satisfies what you were looking for.

M

Yes, I mean I think the more information we can capture at this point, the better, because once people capture it once, they don't always go back and do this stuff again. But I just think there's got be a way of capturing the information now. You can't just say we're going to wait four years until we have some way of categorizing all of these things before we start capturing this information. So I think functional status would obviously be the best if there's a mechanism we can use now to do that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So I'm hearing there's a limited mechanism to do that that will be available in time.

M

So does it make sense to do something in a limited fashion, or does it makes sense to just wait? I guess I look to you all for that answer.

Larry Wolf - Kindred Healthcare - Health IT Strategist

I guess what I'm hearing is that there may be, and again, this would be if there are certification criteria around collecting data … functional status as part of the quality measures, those could serve to begin in some … limited way as the collection of information relevant to disability. So I guess it's saying if I'm hearing it, it's saying that this would be a start.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So the quality measure would drive the collection of relevant information to assess the functional status ….

Larry Wolf - Kindred Healthcare - Health IT Strategist

Right, but again, we have caveat that with that there's a niche there in terms of whether it's a quality measure ends up being in the final rule that is a certification requirement invested in the 12 measures …. So what you heard from Kevin would be the optimistic scenario.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

But I think, Larry, your workgroup's conclusion that the formal, the medical term coding is in preliminary stages is still true. That's probably a tough one to operate on as far as this comment.

Larry Wolf - Kindred Healthcare - Health IT Strategist

So do we have enough of a consensus here to wrap this up and move on because we're down to nine minutes?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So despite the fact that we want to capture this in a usable format, the standards are in the preliminary phase. Is the group agreeable to what's included as proposed by the workgroup, i.e. including stage three?

W

Yes.

W

Yes.

W

Yes.

M

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, okay. Thanks, Larry.

Larry Wolf - Kindred Healthcare - Health IT Strategist

Okay. So there's a final piece here that's not about disability really, but is another area of disparity. HHS and IOM have both looked at sexual orientation and gender identity and are treating them under the same big umbrella that they're treating some of the disabilities. So we were asked to comment on this as well during the some the policy committee meetings, and so this is an area that's also in the process of getting attention and getting standardized. HHS is about to roll this out into their health surveys and I know there's work happening among the experts in the field to try and agree on some standard nomenclature. But clearly, this is not a stage two element, so that's what we're recommending as just something to look at for stage three.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay.

Neil Calman – Institute for Family Health – President & Cofounder

This is Neil again. I just think we're shirking our responsibility here. I think that people have been calling us out since stage one and saying we need to capture these kinds of information in order to look at how the most vulnerable populations are being cared for in our systems and being able to report on that. Stage three is how many years off? I think we have to have a way of capturing it, even if there's no codified method of doing it. We've got to be able to say that certification requires at least a field where this information can be captured, whether it's part of demographics or part of the history. Even if it's not a field that has a specific coding system involved in it, we have to be able to say that it's got to have a way of capturing this information in some reportable field.

I just think to say that for everything that we have to wait till we have some nomenclature that's basically agreed upon by everybody is just not being responsible. We've gotten letters on this issue since stage one.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Well, of course, certifying if there's a lack of a certification criteria, it doesn't mean that people are prohibited from putting it in, right?

Neil Calman – Institute for Family Health – President & Cofounder

No, but it doesn't call out the importance of capturing information and it doesn't make it a requirement to capture the information. This is what I think is what people are saying is critical if you're going to basically be able to look at issues of disparate treatment or disparate outcomes.

Larry Wolf - Kindred Healthcare - Health IT Strategist

So I guess I agree with Neil in terms of the intention here, but I'm really struggling with lack of standards and if we're actually looking to do any kind of reporting.

Neil Calman – Institute for Family Health – President & Cofounder

But think about as … We still call out the importance of capturing progress notes, but we don't have a way of codifying them. Just because we don't have a way to codifying something, it doesn't mean that we can't require that it's captured in the interim and that we're basically saying until we figure this stuff out, we're not calling out the importance of being able to capture this information. I think those are two stages of the same thing. So first we say that it's important to capture it, and it would be nice if we could codify it immediately, but we don't have a mechanism of doing that is what I'm hearing and so I still don't think that that gives us a reason to just sort of ignore it as an important issue.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

We're going to have to call the question, I guess, based on—

Larry Wolf - Kindred Healthcare - Health IT Strategist

Go ahead.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So the workgroup has proposed that it should be taken up in stage three, primarily due to lack of standards, those in favor of that comment?

Carl Dvorak – Epic Systems – EVP

This is Carl and I'm in favor of it, and not out of disrespect for Neil's comments, I just think that the process really should be to determine if it's needed, and if it's needed, set a standard before it's programmed. Otherwise we're going to have 40 members program it 40 ways only to have to change it later.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Other comments, other people's sentiment?

Art Davidson – Public Health Informatics at Denver Public Health – Director

I'm sorry this is Art. I have to step away for a moment, so I know that as far I had asked Kevin for his opinion, but I just didn't understand as I left, was this something that ONC felt was feasible in the shorter term or not?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I don't think there was a comment on this particular one.

Art Davidson – Public Health Informatics at Denver Public Health – Director

So there was some functional status stuff that—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

No, Art, we've moved on to sexual orientation and gender.

Art Davidson – Public Health Informatics at Denver Public Health – Director

Okay, okay, sorry.

W

I thought we covered this in some of the meaningful use recommendations, did we not?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Actually, I did we did, too. I think we agreed with this recommendation.

W

Okay.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

That's correct, you're right. This is … more than once, so the agreement before in the full committee was around this particular recommendation. So those opposed to this?

Neil Calman – Institute for Family Health – President & Cofounder

Me.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes, Neil. Is Neil the only one opposed?

Deven McGraw – Center for Democracy & Technology – Director

I'd like it sooner, too. This is Deven, but it seems, I mean I hope it's a priority at least by three.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay. So I think we're going with the combination of … and the previous, the full committee recommendations, endorsements of the stage three position of this.

Okay, we have only two minutes for the last two. Should I do this?

Larry Wolf - Kindred Healthcare - Health IT Strategist

Okay, so I'll propose the … statement for data portability.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay.

Larry Wolf - Kindred Healthcare - Health IT Strategist

It's a great goal. We don't have sufficient standards to codify everything that's in the record, and that's where we are.

W

Keep going.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So anyone want to comment on that statement? You can make electrons flow, but not the meaning.

Larry Wolf - Kindred Healthcare - Health IT Strategist

That's right. And the other piece is in some of the discussion here is a lot of the issues around being locked into a vendor are not just around the data, but there's a huge investment in training and process and infrastructure. Even if you did have data portability, it's only a small piece of what you would need to move vendors.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

You can't make the blue button bigger, huh?

Larry Wolf - Kindred Healthcare - Health IT Strategist

Sorry. We can, but it may not be all that you need to continue care for somebody.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Other comments? Are people in agreement with this sentiment? Opposed?

Carl Dvorak – Epic Systems – EVP

This is Carl, and I think as I understood it, the recommendation previously was that an EHR be able to output at least a set of CCD document per patient or something of that nature, such that it could be a starting point for transition onto a new EHR. Is that recommendation still on the table?

Larry Wolf - Kindred Healthcare - Health IT Strategist

So we didn't really address that. We were really addressing the much broader issue of could you just swap one in and swap one out kind of thing.

Carl Dvorak – Epic Systems – EVP

Okay, yes, and I agree with your findings. I can't envision a straightforward way to swap one in and swap one out. I was just trying to make sure that this didn't imply that the other still wasn't in play.

Larry Wolf - Kindred Healthcare - Health IT Strategist

Well, I think there's probably value in terms of if you want a snapshot of your patients and something about them as you change from one platform to another, it's probably useful, but it's not the whole record.

Carl Dvorak – Epic Systems – EVP

Understood.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, any disagreement with this recommendation or conclusion, okay, and finally—

Larry Wolf - Kindred Healthcare - Health IT Strategist

Finally, price transparency, pricing is not transparent and that way oversimplifies the discussions, but there's so many different pricing models that people have and there's varieties of what is or isn't included and options of delivery as a service or hosted or run by the provider organization themselves. We just felt like there wasn't a good way to put a price on something. If you just start arbitrarily narrowing the scope of that, you would get meaningless pricing.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, any comments? Okay, agreement with this conclusion?

M
Yes.

W
Yes.

M
Yes.

M
Yes, I agree.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. All right, well, thank you, Larry.

Larry Wolf - Kindred Healthcare - Health IT Strategist
You're welcome. Congratulations to everybody on the committee. It's only two minutes after.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So, no, we have public comment that …. so thank you everybody. Do you want to open it up for public comment, McKenzie, please?

McKenzie
Operator, please open the lines.

Operator
(Instructions given.) We do not have any questions at this time.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay, well, thanks to Micky in his car and to Larry in his airport for making special dispensation to actually do this, and thanks for everyone for making the extra time to finish up this work on these important topics. We will you very soon in Washington.

M
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Thank you now.

W
Thank you, bye.

M
Thank you, bye, bye.

M
Bye.

Public Comment Received During the Meeting

1. Regarding the Audit Log, will this include the DRS - the Designated Record Set, which entails the ancillary systems? Such report becomes more complex, when multiple systems are involved. The DRS may also involve the Accounting of Disclosures report.